SENSITIVE RECORDS: ____YES ____ NO **ETS/RET. DATE: _____ TMC: _____**

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.
AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.
PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.
ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information. This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - PATIENT DATA

1. NAME *(Last, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*	3. SPONSOR'S SOCIAL SEC. NO.
4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*	5. TYPE OF TREATMENT: *(X one)*	
	☐ OUTPATIE ☐ INPATIENT ☐ BOTH	

SECTION II - DISCLOSURE

6. I AUTHORIZE: MARTIN army COMMUNITY HOSPITAL **TO RELEASE MY PATIENT INFORMATION TO:**
(Name of Facility/TRICARE Health Plan)

a. NAME OF PHYSICIAN, FACILITY, OR TRICARE HEALTH PLAN	b. ADDRESS *(Street, City, State and ZIP Code)*
c. TELEPHONE *(Include Area Code)*	d. FAX *(Include Area Code)*

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION *(X as applicable)* ***EMAIL ADDRESS:***

☐	PERSONAL USE	☐	CONTINUED MEDICAL CARE	☐	SCHOOL	☐	OTHER *(specify)*
☐	INSURANCE	☐	RETIREMENT/SEPARATION	☐	LEGAL	☐	*DATE REQUEST RECEIVED _____

8. INFORMATION TO BE RELEASED *(X as applicable)*: _____ **PICK-UP OR** _____ **MAIL**
_____ **ACTIVE DUTY YES OR NO** **DEPENDENT** _____ **RETIRED**_____ **PAPER** _____ **CD** _____ **SAFE** _____

9. AUTHORIZATION START DATE *(YYYYMMDD)*	10. AUTHORIZATION EXPIRATION DATE *(YYYYMMDD)*	☐ ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

I understand that:
a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR 164.524.
d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.
I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT *(If applicable)*	13. DATE *(YYYYMMDD)*

SECTION IV - FOR STAFF USE ONLY *(To be completed only upon receipt of written revocation)*

14. X IF APPLICABLE:	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*
☐ AUTHORIZATION REVOKED		

17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	
Date Mailed: _____ **INT:** _____ **AHLTA** ____ **HAIMS** ____ **ESSENTRIS** ____ **CD** _____ **HC** _____ **INT** ____ _____ ***SIGN:** _____ **DATE:** _____	**SPONSOR NAME:** **SPONSOR RANK:** **FNIP/SPONSOR SSN:** **BRANCH OF SERVICE:** **PHONE NUMBER:**

DD FORM 2870, MAY 2020

Acknowledgement of Military Health System Notice of Privacy Practices

The signature below only acknowedges receipt of the Military Health System Notice of Privacy Practices, effective 14 April 2003

_____ _____

Signature of Patient/Patient representative Date

_____ _____

Printed Name of Patient/Patient representative Relationship

FMP/SPONSOR SSN: _____/_____-_____-_____

_____Patient/Representative Declined to Sign _____MTF Staff Initials

NOTE: The Notice of Privacy Practices (NOPP) pamphlet will be offered to each beneficiary (14 years of age or older) prior to requesting they complete this form. If the patient/representative declines to sign, the MTF staff member will write the FMP and SSN in the space(s) provided above to ensure this document is scanned into the appropriate electronic medical record.

Return this page to Outpatient Records (PAD)

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS

This form is not an authorization or consent to use or disclose your health information.

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN):

10 U.S.C. 136, Under Secretary of Defense for Personnel and Readiness; 10 U.S.C. Chapter 55, Medical and Dental Care; 42 U.S.C. Chapter 32, Third Party Liability for Hospital and Medical Care; 32 CFR Part 199, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); DoDI 6055.05, Occupational and Environmental Health (OEH); and E.O. 9397 (SSN), as amended.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED:

Information may be collected from you to provide and document your medical care; determine your eligibility for benefits and entitlements; adjudicate claims; determine whether a third party is responsible for the cost of Military Health System (MHS) provided healthcare and recover that cost; evaluate your fitness for duty and medical concerns which may have resulted from an occupational or environmental hazard; evaluate the MHS and its programs; and perform administrative tasks related to MHS operations and personnel readiness.

3. ROUTINE USES:

Information in your records may be disclosed to:

- Private physicians and Federal agencies, including the Department of Veterans Affairs, Health and Human Services, and Homeland Security (with regard to members of the Coast Guard), in connection with your medical care;
- Government agencies to determine your eligibility for benefits and entitlements;
- Government and nongovernment third parties to recover the cost of MHS provided care;
- Public health authorities to document and review occupational and environmental exposure data; and
- Government and nongovernment organizations to perform DoD-approved research.

Information in your records may be used for other lawful reasons which may include teaching, compiling statistical data, and evaluating the care rendered. Use and disclosure of your records outside of DoD may also occur in accordance with 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, which incorporates the DoD Blanket Routine Uses published at: http://dpcld.defense.gov/privacy/SORNsIndex/BlanketRoutineUses.aspx.

Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD by DoD 6025.18-R. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION:

Voluntary. If you choose not to provide the requested information, comprehensive health care services may not be possible, you may experience administrative delays, and you may be rejected for service or an assignment. However, care will not be denied.

This all inclusive Privacy Act Statement will apply to all requests for personal information made by MHS health care treatment personnel or for medical/dental treatment purposes and is intended to become a permanent part of your health care record.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

5. SIGNATURE OF PATIENT OR SPONSOR	6. SOCIAL SECURITY NUMBER OR DOD IDENTIFICATION NUMBER OF MEMBER OR SPONSOR	7. DATE *(YYYYMMDD)*

DEPARTMENT OF THE ARMY
UNITED STATES ARMY MEDICAL DEPARTMENT ACTIVITY
6600 VAN AALST BOULEVARD, BLDG. 9250
FORT BENNING, GEORGIA 31905-5637

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

- Provide Release of information form DD FORM 2870
- DoD Identification card
- Complete all highlighted section on DD FORM 2870
- Provide current telephone number and address

To Request records other than for your-self and the patient is over 18 years of age, the following documents are required:

- DoD identification card
- A written consent from the patient concerned, authorizing a third party to act on their behalf. The statement must contain the third party name, date of birth, patient's original signature and must be dated by the patient. (Statement is only good for one time authorization)
- Medical Power of Attorney
- If deceased, a copy of the deceased person's Death Certificate.

DISCLAIMER

I understand that I must allow up to 30 business days from date of request to complete requested medical records. I understand that I am allowed to receive one (1) free copy of my medical records per AR-66 and that this request (if it is a complete record request) will count towards my one free copy. I understand that I will receive a courtesy phone call when my medical records are ready for pick-up and **failure to pick up my medical records after 15 business days of notification will result in destruction of my records. I understand that a fee of $0.13 per page will apply for requesting an additional copy.** I understand all medical records will be issued on Discs per MEDCOM policy, and that all VA entities have signed a Memorandum of Agreement with MEDCOM to take CDs also. I understand that by having a CD I will have a permanent copy of my medical records in PDF at my disposal.

_____ _____
Signature of Patient/Parent/Legal Representative Date

_____ _____
PAD Representative Date

P.O.C. WILLIE BROOKS, SUPERVISOR

PHONE: (762) 408-0076, 0077, or 0078 FAX: (762) 408-0027 or 0028 HOURS: Mon-Fri 0800-1600 www.martin.amedd.army.mil

DEPARTMENT OF THE ARMY
UNITED STATES ARMY MEDICAL DEPARTMENT ACTIVITY
6600 VAN AALST BOULEVARD, BLDG. 9250
FORT BENNING, GEORGIA 31905-5637

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☐	INSURANCE	☐	RETIREMENT/SEPARATION	☐	LEGAL	☐	*Date Request Received: _____

8. INFORMATION TO BE RELEASED: *(X as applicable)*

_____PICK-UP _____MAIL **SENSITIVE: ____BEHAVIORAL HEALTH ____FAP ____ASAP**

UNIT: _____ UNIT PHONE#: _____ *Date Req Sent to B-H: _____

9. AUTHORIZATION START DATE *(YYYYMMDD)*	10. AUTHORIZATION EXPIRATION DATE *(YYYYMMDD)*	
		☐ ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

I understand that:
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☐	AUTHORIZATION REVOKED		*Date Req Approved: _____

17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE

Date Mailed: _____ Int._____

AHLTA____ ESSENTRIS____ HAIMS____ Int._____

SIGN: _____ Date: _____

SPONSOR NAME:
SPONSOR RANK:
FNIP/SPONSOR SSN:
BRANCH OF SERVICE:
PHONE NUMBER:

Call 1-Date: _____ Int._____
Call 2-Date: _____ Int._____
Call 3-Date: _____ Int._____
Call 4-Date: _____ Int._____
Call 5-Date: _____ Int._____